PLEASE PRINT

Tidee label Field		<u>PLEAS</u>	E PRINT	Date of First Appointment Location
D.c. W.A.				
Patient's Name:				Home Phone #
Address:	Street	City	State Zip	Cell Phone #
E-Mail Address:			·	messages: Home Cell C
Date of Birth:	SEX: Male 🖵 Female 🕻	Non-binary	Relationship Status:	Social Security # (last 4 digits)
Have you or any other family	members received medical c	are by our practice? I	f so, Who:	When:
EMERGENCY CONTACT	Γ:	ı	Relationship:_	Contact Phone #
				Phone ()
Group Name:				
Address:				
Address:				Fax # ()
Specialist/Other:				Phone ()
Address:	Charle	Cit	State Zip	Fax # ()
				PCP: Yes No Specialist/Other: Yes No
•	st hear about C	olorado Alle Google® CAAC Patient	ergy and Asthi	ma Centers? (Check One) Friend Other
Patient <u>OR</u> parent/g	guardian of a mine	or		cant other <u>OR</u> the second parent/
Name:	Relationship:		guardian of a	
Date of Birth:	SSN #			Relationship:
E-mail Address:				SSN #
Employer:			E-mail Address:	Phone #
Employer Address:				rnone #
City:			City:	State: Zip:
INICIIDANICE INIC	ODALATIONI (D.::			
INSURANCE INFO	•	2 4	INSURANCE	NFORMATION (Secondary)
Ins Company:Policy Holder/Subscriber:			Ins Company:	
SEX: Male Female			•	er:
Subscriber Address:			SEX: Male Fema	
Subscriber Date of Birth:	SSN #		Subscriber Address:	: SSN #
Subscriber Relationship:				5514#
Ins Address:			Ins Address:	
Member/ID #			Member/ID #	Group:
I have no insurance				
stand I am financially respor I understand and agree if coreferral is current prior to re Patient/Guardian Signature _	nsible for charges not cover are at Colorado Allergy and ceiving care at Colorado A	ed by this authorizat d Asthma Centers req llergy and Asthma C	ion. juires Primary Care Phys enters. If no referral is p Relatio	to Colorado Allergy and Asthma Centers. I under- ician referral, it is my responsibility to see that the present in advance, I agree to pay for charges.
Witness			Date _	
he/she may be evaluated ar sarily limited to, physical exc in effect until revoked by me	a minor (less than eighteend/or treated by Colorado ams, skin tests, laboratory t in writing.	Allergy and Asthma est, allergy injections	Centers' staff if I am not and the prescription of	by parent or guardian, I understand and agree that present to give consent. This may include, but neces-medications in my absence. This agreement will be
Signature				nship to Patient
Witness			Date _	

Colorado Allergy and Asthma Centers, P.C.

New Patient History

Complete the following information. Please put an X in each box that relates to your problems. Use additional page to answer any questions if more room is needed. Patient Name: (Please Print) ______Date of Birth: ________Date of First Visit:_______ ☐ no Were you referred by a physician or other provider? ☐ yes If yes, who _____ Briefly state what problems are bringing you here: Upper Respiratory Tract (Nose, Sinus, Ear, and Eye) Problems Note: If No UPPER Respiratory Tract problems, Check Here 🗆 And Go To Page 2 - Lower Respiratory Tract. When did these symptoms first begin?_ previous nasal or sinus surgery ☐ runny nose ☐ sneezing itching nose ☐ recurrent or chronic sinus infections; if so, how many per year? □ stuffiness nasal congestion post-nasal drip \prod_{0-4} Over 4 decreased or absent sense of smell ☐ sinus x-rays or sinus CT scan done nose bleeds • if so, when? ☐ snoring ☐ abnormal □ normal result □ nasal polyps; if so: □ past □ present ENT evaluation: if so, when? ☐ drainage cough sore throat name of doctor: ______ itchy throat □ bad breath ☐ red ☐ watering ☐ swollen lids Eyes: itch ☐ frequent colds; if so, how many per year? 1-5 ☐ 5-10 ☐ ☐ dark circles ☐ fatigue/tired poor concentration ☐ headaches/sinus pain other: recurrent ear infections ☐ ear plugging/popping/fullness ☐ hearing loss dizziness ☐ septum deviated septum perforated Symptoms Caused Or Aggravated By: □ no Year-round symptoms? □ yes □ cold air □ weather Season(s) in which symptoms are **worst**: ("X" all that apply) □ odors/scents/fragrance ☐ tobacco smoke ☐ winter ummer ☐ fall □ spring ☐ dusting/vacuuming ☐ musty odors/mold \square PM ☐ night \square AM Symptoms worse: ☐ yard work/pollens ☐ being outdoors ☐ aspirin / related medications Symptoms interfere with: sleep □ exercise / activity animals, list: ☐ missed school ☐ missed work other: Symptoms are: \square improving \square worsening \square unchanged List medications tried for **nose/sinus** symptoms (include prescription and over-the-counter oral medications and nasal sprays): **Current Medication** Past Medication Did it work? Does it work? u yes ves ves □ ves □ ves **Office Use Only**

Name			
Name			

Lower Respiratory Tract (Chest, Lung) Problems

Note: If No LOWER Respiratory Tract Probl	ems, Check Here \square And Go To Page 3.
When did chest symptoms first begin? chronic or recurrent cough	 history of recurrent pneumonia history of recurrent croup previous chest x-ray or chest CT scan; if so, when?
Symptoms Caused Or Aggravated By: colds/upper respiratory infections sinus infections exertion/exercise; type: cold air weather change odors/scents/fragrance heartburn/acid reflux emotional stress/anger laughing/crying/cough your workplace or school aspirin/related medications dusting/vacuuming musty odors/mold yard work/pollens being outdoors animals, list: other:	Year-round symptoms? □ yes □ no Season(s) in which symptoms are worst: ("X" all that apply) □ spring □ summer □ fall □ winter Symptoms interfere with: □ sleep □ exercise/activity □ missed school □ missed world Symptoms are: □ improving □ worsening □ unchanged
List medications tried for lower respiratory symptoms (include p Albuterol	Past Medication Past Medication Did it work? yes □ no □ yes □ no

Name:	

Skin Problems

Note: If No SKIN Problems, Check Here \Box And	d Go to 'Previous Allergy Evaluation' below.				
Skin Symptoms:					
□ eczema □ rash	welts/hives skin swelling				
When did skin/eczema symptoms <u>first</u> begin?	When did hives/swelling <u>first</u> begin?				
itching excessively dry, scaly skin	☐ itching ☐ face swelling ☐ hand/foot swelling				
☐ irritated red patches ☐ weepy, oozing rash	☐ lip swelling ☐ tongue /throat swelling ☐ ties:				
recurrent skin infections	difficulty breathing from swelling				
other skin symptoms (list):					
Location of eczema/rash/hives: \square arms \square legs \square trun	ak head neck				
Frequency of above symptoms: \square daily times per wee	k times per month				
Do skin symptoms occur year-round? ☐ yes ☐ no					
Season(s) in which above skin symptoms are worst: \square spring	□ summer □ fall □ winter				
Has a physician diagnosed your rash? ☐ yes ☐ no					
• if yes, what was the diagnosis? \square hives \square eczema	a				
Have you seen a dermatologist for your skin problems? \square yes	no no				
• if yes, name of doctor:	when seen:				
List everything that causes or aggravates your skin symptoms:					
List medications tried for above symptoms (include prescription Current Medication yes no yes	n and over-the-counter oral medications, creams, and ointments): Past Medication Did it work? yes no yes no yes no yes no yes no				
Skin testing: \square no \square yes Blood testing for allergy: \square	□ no □ yes Were you allergic? □ no □ yes				
• if allergic, was it to: □ animals □ dust/mites □ pol	llen □ mold □ food □ other (list):				
Allergist: Name:	State:				
Previous allergy injection(s): \square no \square yes \square If yes, age or	date(s) of treatment:				
If yes, how long did you take shots?	not sure				
Office Use Only					

Name:								
Insect Sting Reaction	is: 🗆 1	no 🛮 yes	If yes, inse	ct(s) causing	reaction:			
• symptoms:			hives	C 1				
• age or date when occ	ured?		(Epi	i-Pen) Epine	ohrine/Adrenalir	device prescribed?	□ no	☐ yes
Drug Allergies / Intol Name Or Type Of Medication		React	☐ yes ion(s) Noted			When Did Reaction Occur? Age or Date	Is The M Complete ☐ yes ☐ yes ☐ yes ☐ yes ☐ yes	Iedication ly Avoided? no no no
Food Allergies / Intol		no React	☐ yes ion(s) Noted			When Did Reaction Occur? Age or Date	Is Th	e Food ly Avoided? no no no no
Latex or Rubber Alle If yes, explain:	_			☐ yes				
Past Medical History	•							
Flu vaccine: \square no \square ye		umonia vacci	ine: 🗆 no 🔲	ves T.	B. test: \square no	☐ yes result: ☐ 1	positive	☐ negative
Birth history (if patient is							•	
			•	•				
Hospitalization(s): \square no								
Surgery(s): none								
Serious injury(s): nor	ne							
Other medical problems: _								
All Current Medication	Dosage		dy listed (In	Medicat		**	ional page i	• /
Family History:								
Do any close family memb		_		-	,			
Hay fever / Allergies Asthma	Father	Mother	Brothers	Sisters	Children	Other diseases that Immune problems Family member:	s 🛮 ye	s 🗖 no
Eczema Sinus trouble						Cystic Fibrosis Family member:	•	
Migraine headache						Emphysema Family member:	•	

	Name:	
Social History:		
Has the patient ever smoked? ☐ no 【	☐ yes If yes, for how many years:	
_	no, when did you quit:	
	Number of packs per day less than 1/2	
	If yes, how often:	
	no uses If yes, how often:	
Deview of Systems (deal all that are		
Review of Systems: (check all that appropriate General	·	
Good general health	Gastrointestinal Does not apply	Neurologic ☐ Does not apply ☐ Sinus headache
_	☐ Difficulty swallowing*	☐ Migraine headache
Weight gain; past year:lbs.	Heartburn / acid indigestion / reflux	☐ Tension headache
Weight loss:lbs.	 stomach acid coming up* frequency:	Hyperactivity/ADD/ADHD
• dieting yes no	• treatment:	☐ Dizzy spells
Excessive tiredness	☐ History of ulcer	☐ Fainting spells
Excessive thirst/drinking	☐ Frequent spitting up or wet burps (infants)	☐ Convulsions/epilepsy/seizures
Recurrent fever	☐ Hiatal hernia	☐ Sleep Apnea
Recurrent night sweats	☐ Recurrent vomiting	☐ Insomnia
☐ Pregnant	☐ Frequent diarrhea	Depression
☐ Planning pregnancy within year	☐ Bloody or black stools	Anxiety
☐ Cancer history	☐ Constipation	Ever see a psychiatrist /psychologist?
• type:	Liver disease:	☐ Currently see one
	☐ History of Hepatitis	_
Eyes	• Hepatitis Type: □A □B □C	Blood / Lymphatic
☐ Dry eyes	• if so, when diagnosed	☐ Blood disorder:
☐ Wear contact lenses	Other problems:	☐ Anemia
☐ Cataracts		☐ Bruise easily
☐ Glaucoma	GI specialist:	Swollen lymph nodes
Giaucoma	• when:	☐ Previous blood transfusion
Mouth /Throat ☐ Does not apply	Genitourinary	☐ Risk factors for AIDS
Excess dryness of mouth	☐ Frequent urination	☐ Testing for HIV
Excessive throat mucus*	☐ Kidney trouble	• if so, result: positive negative
	☐ Bladder infection	n co, recano — pessare — negame
Throat clearing*	Prostate problem (men)	Other symptoms or medical problems (list
Hoarseness or voice problems*	☐ Kidney stones	Other symptoms of medical problems (list
☐ Sensation of something stuck in throat*	Musculoskeletal Does not apply	
Heart ☐ Does not apply	☐ Painful or stiff joints☐ Swollen joints	
Palpitation or pounding of heart	Rheumatoid Arthritis	
☐ Irregular heart beat	Osteoarthritis (age/injury related)	
☐ Angina / chest pain / tightness	Osteoporosis	
☐ History of heart attack	Osteopenia	
☐ Thrombophlebitis/blood clots	☐ Bone Density Test	
☐ Swollen ankles / feet	• date:	
☐ Heart murmurs	Endocrine	
☐ High blood pressure		
-	☐ Thyroid gland problems ☐ Adrenal gland problems	
	Diabetes	ROS reviewed with patient/parent
	☐ Parathyroid disease	MD/PA Initials
		

Name:
Environmental History
How long has patient lived in Colorado? What other states/countries has patient lived in?
Primary Home (for patient living in two homes, also complete "Second Home" below) Type: □ house □ townhouse □ condominium □ apartment □ mobile home □ other: □ Age of home: □ less than 10 years □ 10-20 years □ 20-50 years □ over 50 years □ Length of time in home: □
Construction Basement: □ none □ finished □ unfinished □ walkout □ dirt □ crawl space □ moisture problem
Heat: ☐ forced air heat ☐ hot water or radiant heat ☐ electric heat ☐ woodburning stove ☐ Fireplace; ☐ wood ☐ gast Cooling system: ☐ none ☐ central air ☐ window air conditioner ☐ swamp cooler ☐ attic fan Central filter type: ☐ none ☐ fiberglass ☐ HEPA ☐ electrostatic Frequency of filter change or cleaning:
Mold and Moisture Humidifier: □ none □ furnace □ cold-mist □ ultrasonic □ steam Water leak(s): □ none □ past □ current □ musty odor □ visible mold
Cleaning Frequency of dusting: □ daily □ 2-3 times per week □ 1 time per week □ every 2 weeks □ less often Frequency of vacuuming: □ daily □ 2-3 times per week □ 1 time per week □ every 2 weeks □ less often
Patient's Bedroom Flooring: □ carpet □ wood □ tile □ linoleum □ area rug Bed: Mattress: □ innerspring □ foam □ waterbed □ bunk □ futon Pillow: □ feather (down) □ foam □ synthetic
Pets Sleep in Number How Long Owned? Type/Breed Outside Inside Bedroom □ Dog(s) □ □ □ □ □ □ □ □ □ □ □ □ Cat(s) □ □ □ □ □ □ □ □ □ Other(s) □ □ □ □ □ □ □
Smokers (at your home) ☐ No one ☐ patient ☐ mother ☐ father ☐ husband ☐ wife ☐ other
Other Environments Daycare: Number of days per week Animals Number in room Relatives' Homes: Number of days per week Animals Smokers School/Work: Number of days per week Animals Smokers
Hobbies / Interests
Occupation / School / Daycare Type of work / school / daycare: Kinds of materials exposed to at work / school:
Second Home (for patient living in two homes, please complete the following): Time spent in second home: Smokers:
Pets: Other exposures:
I have reviewed page 1-6 with parent/patient. Date



HIPAA Privacy Notice – Patient Acknowledgement "Health Insurance Portability and Accountability Act"

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Federal Government has required that your medical records remain private, confidential, and unavailable to anyone without your expressed written consent. Our medical record of your care remains the physical property of Colorado Allergy and Asthma Centers, P.C. The State of Colorado supports this law. Forms are used for you to authorize, in writing, the release of a copy of your specific medical records to another entity such as physician, medical practice, or to an insurance company for treatment, payment, and operations of CAAC.

Health Care Operations

There remain certain operational activities when, in the process of delivering medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without expressed written permission of each and every specific occurrence by you. Some examples include:

- Requesting Photo ID at your visit, including for telemedicine visits
- Taking and saving a photograph of the patient for the chart to be used for identification and medical treatment
- Communicating with your pharmacy, insurance carrier, primary care provider, and other professionals involved in the patient's healthcare (such as schools, day care or college heath centers)
- Handling of the mail, newsletters, claims, bills, referrals
- Requesting that the office / reception staff call, text, or email you to schedule an appointment, acquire a
 referral, or to inform you about medications that may have to be held for testing
- Medical staff leaving reasonable and limited messages informing you of potential treatment options such as lab or x-ray results
- Inform you of health-related benefits or services that may be of interest to you
- Verbal or written correspondence with insurance companies; yours and ours
- Discussing an opportunity to enroll you in ongoing Asthma Allergy Research; and/ or continuation in research studies/ clinical trials
- Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care

You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by law: Federal, State or by Court Order. Please note that any unsecure electronic communication initiated by the patient/family is done so at their own risk

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Your Rights under the Law:

You have the right to receive a notice about our	r privacy policy
The right to inspect your protected health inform	mation (PHI) with a provider in a private environment
The right to request a copy of PHI and to have r	returned to you in 30 days, unless notified in writing of 60-day return
The right to request a restriction on uses and di	sclosures of your protected health information
The right to refuse treatment via telemedicine v	visits
The right to request to receive confidential com alternative location	munications from the practice by alternative means or at an
The right to request an amendment of your pro	tected health information
The right to request an accounting of disclosure	es of Protected Health Information (PHI)
The right to revoke or limit authorization	
The right to be notified of a breach of your PHI	
Name/relation	nay receive messages or talk to us regarding patient's medical care. Contact Number
Name/relation	Contact Number
· · · · · ·	, and the second
AC	KNOWLEDGEMENT
	ient, responsible party), acknowledge that I have received a copy of tice's) "HIPAA Privacy Notice-Patient Acknowledgment" document (PHI). I understand that a CAAC "HIPAA Privacy Notice-Detailed"
Patient's or Responsible Party's Signature	Date

You may request at any time a detailed written policy of the Colorado Allergy and Asthma Center's P.C., "HIPAA Privacy Notice- Detailed" or access it at www.coloradoallergy.com

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Financial Policy

Please review this information and sign at the end of the document. By signing this document, the patient/responsibility party is accepting financial responsibility for all services provided.

Colorado Allergy and Asthma Centers (CAAC) will bill your insurance as a courtesy if the company is within the United States. We may provide an estimate of what your insurance company may pay. The insurance company makes the final determination of your eligibility and benefits.

It is your responsibility to notify our office of any patient information changes including address, name, and insurance information.

Insurance Accounts

- 1. I (patient or financially responsible party) will disclose all insurance information including primary and secondary insurance at the time of service. Failure to provide complete insurance information may result in my responsibility to pay the entire bill.
- 2. I agree to pay any portion of the charges not covered by my insurance within 10 days of the statement date. If CAAC is out of network with my insurance company, I will be responsible for any charges above what is paid by my insurance up to the CAAC set fee amount. If my insurance pays me directly, I agree to forward the payment to CAAC immediately.
- 3. I am responsible for any co-payments, co-insurances, deductibles, plus any balance due on non-covered services not paid by my insurance at the time of service. Payments are required within the state's time limitation for paying healthcare claims. The co-payment, co-insurance or deductible requirement cannot be waived. We accept cash, check or credit cards.

Self-Pay Accounts

If you do not have insurance or you choose to not utilize your insurance, we offer a self-pay discount of 25% if payment is received in full at the time of service. Self-pay accounts are for all services for the entire year, or until new insurance is initiated due to a qualifying event.

No Exceptions.

Referrals

- 1. I am responsible for obtaining a referral, if required by my policy.
- 2. I understand if I fail to obtain the referral and/or preauthorization there may be a lower payment or no payment from the insurance company. I will be responsible for the balance due.

Missed Appointments

I understand I may be charged a fee of \$75.00 if I miss or cancel an appointment within 24 hours of the scheduled appointment.

Returned Checks

I understand I will be responsible for a fee of \$35 for a returned check. This will be applied to my account in addition to the insufficient funds amount. All future payments must be paid with a debit/credit card or cash.

Medical Record Copies

I understand I may be responsible for a fee that follows Colorado Department of Health and Environment standard for requesting a copy of my health records.

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Leaders in Allergy & Asthma Care Since 1972



Minor Patients

- 1. By signing this document, I (the parent, guardian) accept financial responsibility for all services provided by CAAC, regardless of who is the subscriber of the insurance policy.
- 2. I understand as the adult (parent, guardian) accompanying a minor, I am responsible for charges at time of service (such as co-payment or deductible).

A divorce decree does not determine which party Colorado Allergy and Asthma Centers, P.C. will bill for medical services. Divorce decrees are only binding upon the two parties who made the agreement.

Payments

- 1. I understand that I am requested to put a credit, debit or HSA card on file. This information is kept strictly confidential and will only be used for payment of fees to CAAC. The card on file will not be charged until the insurance company has reviewed the claim. By processing insurance first, patients will know their exact out-of-pocket responsibility. After the insurance company has completed processing the claim, I will receive an email informing them of the actual amount owed. The email will explain that the card on file will be charged in 3-5 days unless I contact the billing office at 720-858-7550.
- 2. I understand the Financial Information may be provided to the financially responsible party (Guarantor), Subscriber, or the party paying the bill.
- 3. I understand the financially responsible party (Guarantor) is responsible for payments.
- 4. I understand upon default, I am responsible for 24% per annum interest, cost of collections, and attorney fees, even if no lawsuit is filed.
- 5. For patients receiving allergy shots: I understand if I have a past due balance of more than \$100, my antigen will not be mixed until the debt is paid.

Extended payment arrangements are available if needed. Please contact an Account Manager in our Patient Finance Office at 720-858-7550 to discuss payment options.

Please call our Patient Finance Office at 720-858-7550 with any questions or concerns.

Patient's Printed Name

Date of Birth

Financially Responsible Party (PRINT)

Witness Signature

Date

Date

Date

Date

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Breathe Better - Live Better!

MEDICATION ALERT

For skin testing, **hold** any of the following medications or any other over-the-counter or prescription medication, containing an antihistamine, for at least 7 days:

Allegra (Fexofenadine) Alavert (Loratadine)

Actifed

Antivert (Meclizine) Atarax (Hydroxyzine)

Benadryl (Diphenhydramine) Chlor-Trimeton (Chlorpheniramine)

Clarinex (Desloratadine)

Claritin (Loratadine)

Dallergy Dimetane

Dimetapp Doxepin (Silenor) Dramamine

Duravent-DA

Pamprin Max Strength (Pyrilamine

maleate)

Periactin (Cyproheptadine) Phenergan (Promethazine)

Any "PM," "Cold," or "Allergy" Medication

Rondec Sudafed Cold Tavist (Clemastine)

Tylenol PM

Vertin (Meclizine) Xyzal (Levoceterizine) Zyrtec (Cetirizine)

Zzzquil (Diphenhydramine)

Eye drops: May contain Antihistamine:

Alamast Alomide Alocril Bepreve Elestat Lastacaft

Naphcon-A Optivar

Opcon-A Pataday

Patanol Pazeo

7aditor

or OTC Brands

Nose Sprays Containing Antihistamine: Astelin (Azelastine), Astepro, Dymista, Patanase

7 Day Hold:

Axid (Nizatidine)

Pepcid (Famotidine)

Tagamet (Cimetidine)

Zantac (Ranitidine)

Do not stop medication you have been prescribed for other chronic medical conditions, such as heart and lung problems, or inhaled medications for your chest or nose. Do not stop asthma medications. Do not stop Singulair.

Call prescribing doctor for instructions on holding the medications listed below. May interfere with skin testing. Hold for 5 days before appointment.

Antidepressants/Anti-psychotics:

Ludiomil (Maprotiline)

Asendin (Amoxapine) Ativan, Temesta, Tavor, Lorabenz (Lorazepam) Desyrel, Oleptro (Trazodone) Doxepin, Silenor Elavil (Amitriptyline)

Medazepam (Nobrium) Norpramin (Desipramine) Pamelor (Nortriptyline) Remeron (Mirtazapine) Risperdal (Risperidone)

Rivotril, Klonopin (Clonazepam) Seroquel (Quetiapine) Surmontil (Trimipramine) Tofranil (Imipramine) Vistaril (Hydroxyzine) Vivactil (Protriptyline)

Cogentin (benztropine): For Parkinson's Disease, antihistamine properties

Some tranquilizers, cough medications, and sleeping aids may contain an antihistamine. If you have questions about the content of any medications, please call your doctor, pharmacist, or us.

4/2018